MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG TERM CARE REGULATION

ANNUAL FIRE DEPARTMENT CONSULTATION FORM

FACILITY ID NUMBER

SNF/ICF – 19 CSR 30-85.022(43) and RCF – 19 CSR 30-86.022 (5) (A)
ALL FACILITIES SHALL REQUEST CONSULTATION AND ASSISTANCE ANNUALLY FROM A LOCAL FIRE UNIT.

FACILITY NAME	FACILITY TYPE ☐ RCF ☐ ALF ☐ ICF ☐ SNF

ADDRESS (STREET, CITY, ZIP CODE)

OWNER	ADMINISTRATOR/MANAGER

This is to certify that I, the undersigned, have consulted with the Administrator/Manager of the above-named facility and find that this facility is in compliance with all city/county fire prevention codes, and the items indicated below were discussed.

	YES	NO
1. Was assistance given with an actual fire evacuation drill?	☐	☐
2. Was assistance given with fire safety training?	☐	☐
3. Was fire evacuation planning discussed and facility plans reviewed?	☐	☐
4. Was fire protection equipment inspected for maintenance and operation?	☐	☐

REMARKS

FIRE DEPARTMENT REPRESENTATIVE SIGNATURE	PRINT NAME & TITLE	TELEPHONE NUMBER

ADDRESS (STREET, CITY, ZIP CODE)	

RETURN TO:	**MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES** **DIVISION OF REGULATION AND LICENSURE** **SECTION FOR LONG TERM CARE REGULATION** **REGION**
	ADDRESS
	CITY, STATE, ZIP CODE